

PATIENT INTRODUCTION
Salem Plastic Surgery, Inc.

PLEASE COMPLETE AND RETURN TO THE RECEPTIONIST WITH YOUR INSURANCE CARD(S)

(Please Print)

Family Physician: _____ Today's Date: _____
Physician Address: _____
Referring Physician: _____
Physician Address: _____

How did you hear about our practice? _____

Mr.

Patient's Name: Mrs. _____
(First / Middle / Maiden) (Last)

Miss

Race: Caucasian Asian African-American Hispanic Other _____ Age: _____

Social Security Number: _____ Male Female Religion: _____

Patient Date of Birth: _____ Marital Status: Single Married Separated Divorced Widowed

Patient Address: _____ D.L.# _____

No. and Street or Route and Box No.

City

State

Zip

Home Phone Number: () _____ Business Ph Number: () _____ Cell () _____

May we leave a message on your answering machine? Yes No At Home, Yes No At Work, Yes No

E-Mail Address: _____ May we contact you at this e-mail address: Yes No

Patient's Place of Employment: _____ Job: _____

Business Address: _____

Name of Spouse: _____

Spouse Social Security Number: _____ Spouse Date of Birth: _____ Age: _____

Spouse Employer: _____ Business Phone: _____

Business Address: _____ Cell Phone: _____

Person Legally Responsible: _____

Full Name

Relationship to Patient: _____ Phone Number: _____ Cell: _____

Emergency Contact: _____ Phone Number: _____ Cell: _____

INSURANCE INFORMATION

Please present cards to receptionist

Do you have Medicare? Yes No

Do you have Medicaid? Yes No

Insurance (1) _____

Insurance (2) _____

Worker's Comp Claim: Yes No If yes, name of carrier: _____

Phone number for carrier: _____ Contact Person: _____

Employer: _____ Phone: _____

Address to Mail Claim: _____

SIGNATURE REQUIRED ON BACK →